Summary of Benefits: CDHP

CDHP Cost-Sharing: Annual Deductible, Out-of-Pocket Limits; and Health Reimbursement Account (HRA) Funds	Member's Share of Covered Charges	
	Preferred Provider (PPO) (In-Network)[1,2]	Nonpreferred Provider (Out-of-Network)[1,2]
Calendar Year Deductible: Family deductible is an aggregate of two times the Individual amount and may be met by two or more family members.[1]	$1500/Individual $2250/Employee + Adult **OR** $2250/Employee + Child(ren) $3000/Family	
Calendar Year Out-of-Pocket Limit: Includes coinsurance only - does **not** include residential treatment center copayments or deductible. Family limit may be met by two or more family members.[2]	Individual - $2750 Employee + Adult - $4125 Employee + Child(ren) - $4125 Family - $5500	Individual - $8500 Employee + Adult - $12,750 Employee + Child(ren) - $12,750 Family - $17,000
Lifetime Maximum Benefit Limit (per member)	Unlimited	**$2,000,000**
Health Reimbursement Account (HRA): Used to offset the Medical Program deductible, copayments, and coinsurance. If you do not use all HRA funds during a calendar year, the remaining amount will roll over to the following year, for up to a three-year cap on rolled over dollars.	Individual - $750 per calendar year Employee + Adult - $1125 per calendar year Employee + Child(ren) - $1125 per calendar year Family - $1500 per calendar year	

HRA-Only Medical Expenses: The following expenses are payable only by using HRA funds: qualified medical expenses per Section 213(d) of Internal Revenue Code that are not covered under the Medical Program; smoking cessation or weight loss programs; difference in cost between a brand-name and a generic drug; COBRA premiums.

CDHP Medical Program Covered Services and Limitations	Member's Share of Covered Charges	
	Preferred Provider (PPO) (In-Network)[1,2]	Nonpreferred Provider (Out-of-Network)[1,2]
Office Visit/Exam Charge	10% after deductible	40% after deductible
Family Planning (including devices, insertion, Depo-Provera, etc.)	10% after deductible	40% after deductible
Allergy Injections	No copay (*deductible waived*)	40% after deductible
Allergy Care (such as allergy testing; extract preparation)	10% after deductible	40% after deductible
Therapeutic Injections; Office Surgery and Supplies	10% after deductible [4]	40% after deductible [4]
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive)	10% after deductible [4]	40% after deductible [4]
Nutritional Counseling (**3 sessions/life** for certain conditions)	10% after deductible	40% after deductible
Routine/Preventive Well-Baby Care (Through Age 2): Routine check-ups; routine screenings; routine laboratory tests; immunizations	No Copay (*deductible waived)*	40% *(deductible waived)*
Routine/Preventive Well-Child Care (Ages 3-18): Routine physicals and exams, well-child care; immunizations, routine vision/hearing screenings	No Copay (*deductible waived)*	40% after deductible
Routine/Preventive Adult Care (Ages 19 and Older): Routine adult physicals and gynecological exams; colonoscopies, immunizations	No Copay (*deductible waived)*	40% after deductible
Routine/Preventive Lab, X-Ray, and Other Testing (Ages 3 and Older): Including Pap tests, mammograms, cholesterol tests, urinalysis, EKGs	No Copay (*deductible waived)*	40% after deductible
OTHER MEDICAL/SURGICAL SERVICES		
Acupuncture (limited to **20 visits**/year)	10% after deductible	40% after deductible
Ambulance: Emergency Transport (Air/ground ambulance, as needed)	10% after deductible[3]	
Ambulance: Nonemergency Ground Transfer (between facilities)	10% after deductible[4]	
Ambulance: Nonemergency Air Transfer (between facilities)	10% after deductible[4]	40% after deductible[4]
Emergency Room Visit (*emergency* condition only; including facility, physician and other professional provider charges)	10% after deductible [3]	

This is a summary ONLY of benefits available under the CDHP + HRA Medical Program. Conditions of coverage, limitations, and exclusions apply. See a benefit booklet for details.

CDHP Medical Program Covered Services and Limitations (continued)	Preferred Provider (PPO) (In-Network)[1,2]	Nonpreferred Provider (Out-of-Network)[1,2]
Cancer/Congenital Heart Disease Care (Blue Distinctions programs only include a food/lodging per diem benefit of **$50** per person, or $100 per day for 2-3 persons. Travel and the above per diem allowances combined are limited to **$10,000** per lifetime for each program utilized. If program is not used, benefits are same as for any other service, based on place of treatment, provider contract, and type of service.)	10% after deductible[4,5]	40% after deductible[4,5]
Cardiac and Pulmonary Rehabilitation, Outpatient/Office	10% after deductible[4]	40% after deductible[4]
Dental/Facial Accident[3], Oral Surgery, TMJ/CMJ Services (for limited, non-dental medical conditions; see a benefit booklet for details)	10% after deductible[4]	40% after deductible[3,4]
Hearing-Related Services - Office exams and evaluations; cochlear implant; auditory testing - Hearing aid services (maximum benefit of **$2,200** during 36-month period, including fitting of hearing aid and ear molds)	10% after deductible	40% after deductible
Home Health Care/Home I.V. Services (Private duty nursing **not** covered; care must be from a licensed home health care agency): - Skilled nursing services (Out-of-network limited to **$8,000/**calendar year) - Other home health care agency services and home I.V. services (Out-of-network limited to **100** visits/calendar year)	10% after deductible[4]	40% after deductible[4]
Hospice Services including bereavement counseling when such services are provided by hospice (Lifetime benefit for hospice care limited to **$7,400;** respite care limited to **10 days** for each 6-month benefit period.)	10% after deductible[4]	40% after deductible[4]
Hospital/Other Facility: Inpatient		
- ***Medical/Surgical Acute Care, Observation, Medical Detox, and Extended Stay (Nonroutine) for Covered Newborn:*** Room, Board, Covered Ancillaries	10% after deductible[5]	40% after deductible[5]
- ***Maternity Hospital Fees and Birthing Center***	10% *(deductible waived)* [5]	40% after deductible[5]
- ***Skilled Nursing Facility*** and *Inpatient* ***Physical Rehabilitation*** (max. **100 days** per calendar year for preferred and nonpreferred combined; in addition, nonpreferred services cannot exceed **70 days** per calendar year)	10% after deductible[5]	40% after deductible[5]
- *Inpatient* ***Physician's Medical Visit*** *or* ***Consultation***	No copay *(deductible waived)*	40% after deductible
- *Inpatient* ***Surgeon, Anesthesiologist, Radiologist, Pathologist, and Assistant Surgeon*** (includes all physician maternity care and OB/midwife delivery charges, pre- and post-natal care, but excluding initial visit to provider, which is subject to regular office provisions)	10% after deductible	40% after deductible
Hospital/Other Facility: Outpatient (Includes covered services, whether billed by facility or professional provider, including surgery, diagnostic tests, chemotherapy, dialysis, and radiation treatment.)	10% after deductible *(deductible waived for maternity care)* [4]	40% after deductible[4]
Lab, X-Ray, and Other Diagnostic Tests (nonroutine/nonpreventive) Including MRI, CT Scans, and PET Scans; EKGs, etc. *- Office or Freestanding/Independent Facility; Outpatient Hospital*	10% after deductible *(deductible waived for maternity care)* [4]	40% after deductible[4]
Maternity Care *- Initial visit to confirm pregnancy* *- All other expenses*	10% after deductible 10% *(deductible waived)* [5]	40% after deductible[5]
Short-Term Rehabilitation, Outpatient and Office (Includes outpatient and office physical, occupational, and speech therapy services, each of which is limited to **20 visits**/calendar year. Speech therapy is limited to specified medical conditions; see a benefit booklet for details.)	10% after deductible[4]	40% after deductible[4]
Spinal/Osteopathic Manipulation (Max. **20 visits**/calendar year)	10% after deductible	40% after deductible
Supplies, Durable Medical Equipment, Prosthetics, Orthotics (Support hose up to **6**/year. Mastectomy bras limited to **3/**year. For diabetic supplies such as needles, test strips, glucagon, etc., see drug plan provision.)	10% after deductible [4,6]	40% after deductible [4,6]
Surgery: Outpatient, Ambulatory Surgery Center, or Office (including related surgeon, pathologist, radiologist, etc.)	10% after deductible[4]	40% after deductible [4]
Therapy: Chemotherapy, Dialysis, and Radiation	10% after deductible [4,5]	40% after deductible [4,5]
Transplant Services: Limitations apply to donor charges and travel, food, and lodging. Must be received at a facility that contracts with BCBSNM or with the national BCBS transplant network. Benefits for bone marrow/stem cell donor search limited to **$25,000** in a lifetime.	10% after deductible[4,5]	No benefit
Urgent Care Facility	10% after deductible	40% after deductible

CDHP Medical Program Covered Services and Limitations (continued)	Preferred Provider (PPO) (In-Network)[1,2]	Nonpreferred Provider (Out-of-Network)[1,2]
Travel, Food, and Lodging: Benefits are available when these services are related to case-managed Cancer Services, Congenital Heart Disease, and Transplant Services if patient is receiving treatment from a Blue Distinctions Center for Specialty Care. Travel of more than 50 miles must be necessary in order to be eligible for coverage under this provision.		
Travel to and from health care facility plus per diem payments listed below	$10,000/lifetime after deductible[4]	
Food and lodging **per diem** for patient and/or companion(s)	$50/individual or $100 for 2-3 persons after deductible[4]	
BEHAVIORAL HEALTH: Mental Health and Chemical Dependency		
Mental Health Services *-Office, Outpatient, Intensive Outpatient Programs (IOP); Inpatient and/or Partial Hospitalization*	10% after deductible (no copay for inpatient physician) [4,5]	40% after deductible[4,5]
Chemical Dependency Rehabilitation *-Office, Outpatient, Intensive Outpatient Programs (IOP); Outpatient/Suboxone Treatment; Inpatient and/or Partial Hospitalization*	10% after deductible (no copay for inpatient physician) [4,5]	40% after deductible [4,5]
-Residential Treatment Center (max. **130 days**/lifetime), including physician	$250 + 20% after deductible [4,5,7]	$250 + 40% after deductible [4,5,7]

DRUG PLAN: Prescription Drugs, Insulin, Diabetic Supplies, Nutritional Products, Specified Vaccines [8]			
Enteral nutritional products, compounded medications, special medical foods, and certain other drugs require prior approval or benefits will be denied.	Generic Drug	Brand-Name Drug [8]	
		No generic available	Generic available[8]
Retail Pharmacy/Specialty Pharmacy Programs (up to a 30-day supply or 180 units, whichever is less; benefits include flu, pneumococcal, and Zostavax vaccines for which no copayment is required)	You pay 20% of covered charges after deductible	You pay 20% of covered charges after deductible	You pay 20% of covered charges after deductible
Mail-Order Program (up to a 90-day supply or 540 units, whichever is less)			
Nonprescription Enteral Nutritional Products and Special Medical Foods (up to a 30-day supply per 30-day period; requires prior approval)	You pay 20% of covered charges after deductible		

FOOTNOTES:

1 All services are subject to deductible unless otherwise indicated in the *Summary of Benefits* (i.e., "deductible waived"). When applicable, the deductible must be met before benefit payments are made.

2 After you reach an out-of-pocket limit, the Plan pays 100 percent of most of your covered Preferred Provider (In-Network) or Nonpreferred Provider (Out-of-Network) charges, whichever is applicable, for the rest of the calendar year (excludes copayments for residential treatment and deductible). Items covered under the drug plan are subject to the Preferred Provider (In-Network) out-of-pocket limit. Preferred Provider (In-Network) expenses do **not** cross-apply to the Nonpreferred Provider (Out-of-Network) limit or vice versa.

3 Initial treatment of a medical emergency is paid at the Preferred Provider (In-Network) benefit level. Follow-up treatment and treatment that is not for an emergency is paid at the Nonpreferred Provider (Out-of-Network) level.

4 Certain services are not covered if prior approval is not obtained from BCBSNM (or Mesa Mental Health). A list of such services is in the benefit booklet. Some services may require a written request for prior approval in order to be covered. (Nonemergency ambulance services are covered **only** when it is medically necessary to transfer the patient from one facility to another.)

5 Admission review approval is required for inpatient admissions. Some services, such as transplants and physical rehabilitation, require additional approval. If you do not receive prior approval for these individually identified procedures and services, benefits for any related admissions will be denied. The $300 penalty will not apply in such cases. You pay a $300 penalty for covered out-of-network inpatient facility services if approval is not obtained in advance.

6 Rental benefits for medical equipment and other items will not exceed purchase price of a new unit.

7 Extended care facilities (such as nursing homes and residential treatment centers) are excluded from coverage. However, LANS has authorized the Claims Administrator to approve, when used as a cost-effective alternative to inpatient hospitalization, up to 130 days of residential treatment center services for patients being treated for chemical dependency. This is a lifetime maximum that accrues from Medical Program to Medical Program and is the only exception that can be made to the extended care facility exclusion.

8 Prescription drugs must be purchased at a pharmacy that participates in the Retail Pharmacy/Specialty Pharmacy Drug or Mail-Order Service Programs. (BCBSNM has contracted with a separate program for administration of your prescription drug benefits.) If you require a brand-name drug for which there is a generic equivalent, you will pay the difference in cost between the brand-name drug and the generic drug, plus the deductible (if not met) and the 20 percent coinsurance amount.

NOTE: Deductibles, copayments, and coinsurance percentages are applied to BCBSNM's covered charges, which may be less than the provider's billed charges. Preferred providers will not charge you the difference between the covered charge and the billed charge for covered services; nonpreferred providers may.